August 4, 2016

Secretary Sylvia Matthews Burwell
Department of Health and Human Services
330 Independence Avenue SW
Washington, DC 20201

Dear Secretary Burwell,

On behalf of the over 29 million Americans living with diabetes and the 86 million more with prediabetes, the American Diabetes Association (Association) provides the following comments and recommendations regarding the *Healthy Ohio Program 1115 Demonstration Waiver Application*.

According to the Centers for Disease Control and Prevention, over 1 million adults in Ohio have diabetes and 570,000 more are have prediabetes. Access to affordable, adequate health coverage is critically important for all people with, and at risk for, diabetes. When people are not able to afford the tools and services necessary to manage their diabetes, they scale back or forego the care they need, potentially leading to costly complications and even death.

Adults with diabetes are disproportionately covered by Medicaid.[1] For low income individuals, access to Medicaid coverage is essential to managing their health. As a result of inconsistent access to Medicaid across the nation, these low income populations experience great disparities in access to care and health status, which is reflected in geographic, race and ethnic differences in morbidity and mortality from preventable and treatable conditions. For example, a study conducted in California found "amputation rates varied tenfold between the highest- and lowest-income neighborhoods in the state."[2] Medicaid expansion made available through the Affordable Care Act (ACA) offers promise of significantly reducing these disparities.

As such, the Association strongly supports Ohio's decision to continue its Medicaid expansion program. However, we are very concerned by some of the provisions in the Healthy Ohio Program 1115 Demonstration Waiver. In particular, we believe the monthly contribution requirements for enrollees, the cost-sharing amounts for services, and the "incentives" for individuals to not use medical care in order to reduce their contribution requirements in the future could have a negative impact on Ohio Medicaid enrollees with diabetes. We respectfully provide the following comments and recommendations ensure the needs of low-income individuals with diabetes continue to be met by the state's Medicaid program.

<u>Cost-Sharing and Financial "Incentives"</u>

The Kaiser Commission on Medicaid and the Uninsured reports that "a large body of research shows that premiums and cost-sharing can act as barriers in obtaining, maintaining and accessing health coverage and health care services, particularly for individuals with low incomes and significant health care needs."[3] The Association is concerned by the amount of monthly contributions Ohio Medicaid enrollees will be required

to pay in order to continue coverage. In general, cost-sharing deters individuals from seeking medical care, while premium requirements deter individuals from enrolling in coverage. According to a study conducted by staff at the Agency for Healthcare Research and Quality (AHRQ), a premium increase of $10 per month is associated with a decrease in public coverage of children in families with incomes above 150% of the federal poverty level (FPL), with a greater decrease in coverage for those below 150% FPL.[4] The price sensitivity of households with low incomes *must* be a consideration when imposing premium or co-payment requirements for any public health program. Fortunately, federal Medicaid regulations prohibit premiums for most individuals with income below 150% FPL.[5]

We are concerned that, even though enrollees will not have to pay additional cost-sharing for services if they have exhausted the funds in their Buckeye Accounts, the levels of cost-sharing for services will greatly impact beneficiaries' ability to achieve the "incentive" of rolling-over unused funds to be able to pay less in the following year. Further, the Association is very concerned this financial "incentive" scheme will be particularly detrimental to enrollees diagnosed with diabetes.

Diabetes is a complex, chronic illness requiring continuous medical care with multifactorial risk reduction strategies beyond glycemic control. Ongoing patient self-management education and support are critical to preventing acute complications and reducing the risk of long-term complications. The Association, including its scientific and medical experts, believes essential benefits for the management, prevention, and care of diabetes include:

- Diabetes screening for individuals at high risk;
- Services as determined by a treating health care provider;
- Prescription medications;
- Durable medical equipment, such as blood glucose testing equipment and supplies, and insulin pumps and associated supplies;
- Services related to pregnancy, including screening for diabetes; monitoring and treatment for women with pre-existing diabetes and gestational diabetes; and postnatal screening;
- A yearly dilated eye exam by an eye-care professional with appropriate follow-up care as medically needed;
- Podiatric services;
- Diabetes education, including diabetes outpatient self-management training services; and
- Medical nutrition therapy services.

Providing a Healthy Ohio Program enrollee with diabetes a financial incentive to *not* use medical services—and therefore have a remaining balance in the Buckeye Account at the end of the year—is inappropriate, and could result in increased costs for the state and federal government in the long-term. For example, studies show intensive diabetes management can delay the onset and progression of diabetic nephropathy, which is the leading cause of end stage renal disease.[6] If a low-income individual with diabetes is enrolled in the Healthy Ohio Program, the financial incentive offered by the program may dissuade him from obtaining the medical care, supplies and medications he needs to manage his diabetes.

This type of incentive is counter-intuitive and could potentially be harmful in the long-term to Healthy Ohio Program enrollees with diabetes.

The state is also proposing to use so-called "healthy behavior" incentives, which allow program enrollees to pay for benefits not covered by the program and to enable them to roll-over the full amount remaining in their Buckeye Accounts at the end of the year. The Association has concerns with wellness programs that use premium (or other health care cost) rewards and penalties tied to achievement of a health status or outcome. Use of such incentives should in no way jeopardize access to Medicaid benefits or be used as a proxy for discrimination on the basis of health status. **We strongly urge CMS to require the state to explicitly define what "healthy behaviors" it will require in order for beneficiaries to receive incentive points and to roll-over the full remaining balance of their Buckeye Accounts**. If those "healthy behaviors" change during the demonstration program, CMS should require the state to seek a waiver amendment with a public comment period. In addition, the Association strongly urges CMS to ensure all "healthy behavior" incentive programs proposed by the state comply with all of the applicable federal statutes relating to non-discrimination.

Alternative Benefit Plan and Essential Health Benefits Requirements

In addition to the potential long-term clinical impacts which could result from the inappropriate incentives offered through the Healthy Ohio Program, the Association is also concerned the proposed program does not meet the requirements of the Affordable Care Act (ACA) as it relates to the new adult eligibility group. We are particularly concerned the proposed incentive scheme violates Section 1302 of the ACA which says that in defining the Essential Health Benefits (EHB) the Secretary of the Department of Health and Human Services shall "not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life."[7] Section 2001 of the ACA requires states to provide beneficiaries in the new adult group benchmark or benchmark equivalent coverage (called an alternative benefit plan or ABP), as outlined in Section 1937 of the Social Security Act.[8] The ACA also modified the requirements of Section 1937 to require benchmark benefits to, at a minimum, include EHB.[9] Therefore, individuals in the new adult eligibility group must receive Section 1937 ABP coverage which includes a non-discriminatory EHB package.

While it appears the benefits package options for the new adult eligibility group outlined in the Healthy Ohio Program may meet the Section 1937 requirement of covering EHB, the incentive program discriminates against individuals with disabilities—including those with diabetes—in violation of Section 1302 of the ACA. Even if program enrollees who have diabetes make all of the required monthly payments and meet the healthy behavior requirements, their need for regular medical care to treat and manage their diabetes puts them at a great disadvantage in achieving the offered incentive compared to program enrollees who do not have diabetes.

Further, under the ACA, certain individuals in the new adult eligibility group "must be given the option of an ABP that includes all benefits available under the approved State plan."[10] This exemption includes individuals who are deemed "medically frail" by the state, the definition of which must at least include

individuals with "serious and complex medical conditions."[11] While we recognize the Healthy Ohio Program benefits are the same as the State Plan benefits, the financial incentives and penalties are not. **Therefore, we strongly urge CMS to require the state to include in the Healthy Ohio Program an exemption for those deemed medically frail, in compliance with the federal Medicaid rules.** This exemption should provide medically frail Medicaid enrollees with the option to participate in the Healthy Ohio Program, or to receive their coverage through the state's traditional Medicaid program.

Summary

The Association is pleased that as a result of Medicaid expansion, 650,000 previously uninsured Ohioans now have health care coverage.[12] But we are concerned the program outlined in the draft Healthy Ohio Program 1115 Demonstration Waiver is not "likely to assist in promoting the objectives" of the Medicaid program as required in Section 1115 of the Social Security Act.[13] In fact, in its waiver application, the state estimates this new program will result in a 9% decrease in Medicaid enrollment. In addition to causing a drop in Medicaid enrollment, the Association believes the proposed incentives are potentially detrimental to the health of Healthy Ohio Program enrollees with chronic health conditions, such as diabetes. Further, the Healthy Ohio Program financial roll-over incentives discriminate against individuals with diabetes. As such, the Association strongly urges the Secretary to ensure individuals with disabilities, such as diabetes, enrolled in the Healthy Ohio Program are not at a disadvantage and are able to access all of the care necessary to manage their condition and avoid costly and devastating complications.

We appreciate the opportunity to provide comments on the draft Healthy Ohio Program 1115 Demonstration Waiver. If you have any questions, please contact me at lmciver@diabetes.org or (703) 299-5528.

Sincerely,

LaShawn McIver
Vice President, Public Policy and Strategic Alliances
American Diabetes Association

[1] Kaiser Commission on Medicaid and the Uninsured, The Role of Medicaid for People with Diabetes, November 2012. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_d.pdf

[2] Stevens CD, Schriger DL, Raffetto B, et. al, Geographic Clustering of Diabetic Lower-Extremity Amputations in Low-Income Regions of California, 8 Health Affairs 33, August 2014

[3] Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, Kaiser Commission on Medicaid and the Uninsured, February 2013.

[4] Abdus S, Hudson J, Hill SC, Selden TM, Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children, 33 Health Affairs 8, August 2014.

[5] Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, Kaiser Commission on Medicaid and the Uninsured, February 2013.
[6] American Diabetes Association, Standards of Medical Care in Diabetes—2014, Diabetes Care, S43, January 2014. Available at http://care.diabetesjournals.org/content/37/Supplement_1/S14.extract
[7] Patient Protection and Affordable Care Act, Public Law 111-148, §1302(b)(4)(B), March 23, 2010. Note: Through rulemaking the Secretary allowed states to define EHB through a benchmark plan process.
[8] Patient Protection and Affordable Care Act at § 2001(a)(2)(A).
[9] Patient Protection and Affordable Care Act at § 2001(c)(3).
[10] 42 C.F.R. § 440.315.
[11] 42 C.F.R. § 440.315(f).
[12] Ohio Governor's Office of Health Transformation, Extend Medicaid Coverage to More Low-Income Ohioans. Available at http://www.healthtransformation.ohio.gov/Budget/ExtendMedicaidServices.aspx
[13] 42 U.S.C. § 1315(a).